

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ALR-0028</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/08/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>METHODIST HOME OF DC-FOREST SIDE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2701 MILITARY ROAD NW WASHINGTON, DC 20015</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	<p><b>Initial Comments</b></p> <p>An initial licensure survey was conducted on March 8, 2011, to determine compliance with the Assisted Living Law " DC Code § 44-101.01 " a tour of the facility and a review of the facility's policies and procedures found the facility to be in compliance with the regulations required for initial licensure.</p>	R 000			

Health Regulation Administration

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1